PASRR/DU Level II Evaluation

For BOCK use only

RedCap ______________ ☐ Pre-Admission Screening ☐ Resident Review

PASRR Outcome: ☐ SMI ☐ IDD/RC ☐ Unable to verify SMI ☐ Unable to verify IDD/RC ☐ Primary Dementia

Specialized Services? ☐ No ☐ Yes/MI ☐ Yes/ID

Re-evaluation required? ☐ No ☐ 180 days ☐ Other: ______________

SECTION I: Identification

1. Name (Last, First, MI) ______________ 2. Date of Birth ______________ 3. Gender Male ☐ Female ☐

4. DCN ______________ 5. Evaluation Date ______________ 6. Type: ☐ On-Site ☐ Telehealth

7. Current Location: NF ☐ Hospital ☐ Home ☐ RCF/ALF ☐ ISL ☐ Other ☐ ______________

8. Facility Name ______________ Admit Date ______________

City ______________

Contact ______________ Phone ______________

9. Does the individual have a **LEGAL GUARDIAN?** No ☐ If Yes, complete the following:

Name ______________

Address ______________

City ______________ State ____ Zip Code ______________

Relationship: ______________ Phone ______________

SECTION II: Psychosocial Assessment

1. Is English the individual's primary language? Yes ☐ No ☐

If No, primary language is: ______________ Were interpretive services used during evaluation? Yes ☐ No ☐

2. Marital Status: ______________

3. Describe current **family** state. What kind of support system/resource is the family? Who are the primary contacts?

4. Describe historical/past and most recent **living situation.**

SECTION II: Psychosocial Assessment (continued)

5. Prior medical and **support systems (check all that apply):**

- ☐ None
- ☐ Home health
- ☐ Family assistance
- ☐ Medication supervision/set-up/administration
- ☐ Personal care/ADL assistance
- ☐ Housekeeping
- ☐ Meal preparation/home delivered meals
- ☐ Shopping assistance
- ☐ Respite services
- ☐ Adult day care program
- ☐ Financial management
- ☐ Other (church, friends etc): ____________________

6. Specify reason for **NF application, admission or continued stay(check all that apply)**

- ☐ Assistance needed to complete ADLs (eating, dressing, grooming, bathing, incontinence care)
- ☐ Assistance needed for transfers, ambulation, fall prevention
- ☐ Rehabilitation services needed (physical, occupational, speech therapy)
- ☐ Medical treatment and/or monitoring for acute conditions
- ☐ Medical treatment and/or monitoring for chronic conditions
- ☐ Dementia symptoms requiring 24 hr monitoring/management
- ☐ Behavioral difficulties and/or mental illness symptoms requiring 24 hr monitoring/management
- ☐ Lack of community/family supports to maintain functioning at home
- ☐ Alternative care options are unavailable (waiting lists, etc)
- ☐ Other ____________________

7. Describe current and historical education/academic development/functioning learning skills.

8. Describe current and historical work experience/vocational development skills, including present vocational skills.

SECTION III: Psychiatric Assessment/History

1. Please list all documented historical and current psychiatric and ID/DD **diagnoses** (include date of diagnosis if available).

SECTION III: Psychiatric Assessment/History (continued)

2. Describe any **medical conditions** that could exacerbate, mimic, be related to mental illness symptoms, or be considered a DD related condition.

3. Does the individual have a history of traumatic experiences which may include physical, emotional or sexual **abuse**, domestic violence, neglect, or exploitation? If Yes, specify: ☐ No

4. Describe **historical symptoms** or behaviors indicating a psychiatric disorder and time of onset.

5. Describe any **previous psychiatric treatment** including hospitalizations, outpatient treatment, etc. Include services received through the Missouri Department of Mental Health.

SECTION III: Psychiatric Assessment/History (continued)

6. Describe any **current/historic DMH/DD regional office services** (include dates and types of services as available).

7. Does the individual have a history of **alcohol and/or drug use**? No ☐

If Yes, describe use and treatment/services including services received through the Missouri Department of Mental Health.

Describe current/recent use: ______________________

8. **Current** psychiatric support/services. **Mark all that apply.**

☐ None
☐ Psychiatric follow-up/consultation
☐ Day program/partial hospital program
☐ Inpatient psychiatric treatment
☐ Individual therapy/counseling
☐ Medication administration/management/monitoring
☐ Sheltered workshop
☐ Supported community living/Independent supported living
☐ Group therapy/counseling
☐ Secured/behavioral unit
☐ ECT
☐ Safety precautions (specify): ______________________
☐ Other (specify): ______________________

9. Any history OR current thoughts/plans/acts/ideation or intention of **suicide or self injury**? ☐ No ☐ Unknown If yes, describe:

10. Any history OR current thoughts/plans/acts/ideation or intention of **homicide, aggressive/assaultive or violent** behavior? ☐ No ☐ Unknown If yes, describe:

SECTION IV: Behavioral Assessment

1. Overt Behaviors None ☐ If yes, please indicate which of the following behaviors are problematic for the individual within the last 30 days based on the individual's medical record or staff comments.

☐ Unsafe smoking behavior	☐ Impatient/demanding	☐ Cursing/swearing	☐ Suspicious of others
☐ Refuses medications	☐ Wandering	☐ Disturbs other residents	☐ Lies purposefully
☐ Refuses activities	☐ Alcohol/drug use	☐ Physically threatening	☐ Steals deliberately
☐ Refuses to eat	☐ Destroys property	☐ Strikes others provoked	☐ Talks of suicide/ideation
☐ Uncooperative with diet	☐ Exposes self	☐ Strikes others unprovoked	☐ Passive death wish
☐ Uncooperative with hygiene	☐ Sexually aggressive	☐ Elope/leave facility	☐ Suicide threats
☐ Self induced vomiting	☐ Verbally abusive	☐ Seclusiveness	☐ Suicide attempts
☐ Frequent/continuous yelling	☐ Verbally threatening	☐ Injures self	☐ Verbalizations or crying out
☐ Intrusive/invades others space	☐ Uncooperative with medical/nursing care or treatments		

☐ Other (specify): ______________________

2. Describe frequency and intensity of behaviors and staff response to behaviors noted above. ☐ NA

3. Placement in Seclusion/Restraints. In the last 30 days has the individual been placed in seclusion or restraints to control dangerous behavior? ☐ No If yes, describe:

4. Typical **Daily Activities**. Per individual and/or staff report describe how the individual spends most of her/his time (important activities, hobbies, interests).

SECTION V: Level of Functioning

Coding: I = Independent V = Verbal assist, supervision, or set up P = Physical assist

1. Personal care and independent living skills:

______ Toileting	______ Bathing	______ Scheduling of medical treatments
______ Personal hygiene	______ Eating	______ Monitoring of health status
______ Brushing teeth/oral care	______ Meal preparation	______ Maintaining personal safety
______ Laundry/Care of clothing	______ Housekeeping	______ Budgeting and personal finance
______ Selects appropriate clothes	______ Shopping	______ Handling money
______ Dressing/undressing		

SECTION V: Level of Functioning (continued)

2. Mobility/Gait **(mark all that apply)**

- ☐ Normal/Fully independent
- ☐ Aids (cane/walker)
- ☐ Unsteady
- ☐ Staff assist
- ☐ Wheelchair unassisted
- ☐ Wheelchair assisted
- ☐ Bedfast
- ☐ Other: ______________________

3. Sensorimotor development. Does the individual have impairment in the following areas? ☐ No **If Yes, check all that apply**

- ☐ Ambulation
- ☐ Gross motor dexterity
- ☐ Eye-hand coordination
- ☐ Positioning
- ☐ Visual motor perception
- ☐ Fine motor dexterity
- ☐ Transfers

4. Could prosthetic, orthotic, corrective or **mechanical supportive devices** improve the individual's functional capacity? ☐ No If yes, describe:

5. Describe the individual's speech and language **(communication)** development, such as expressive and receptive language (verbal and nonverbal).

6. Could **non-oral communication systems,** amplification devices or a program of amplification improve the individual's functional capacity? ☐ No If yes, describe:

7. Describe the individual's **social development** such as interpersonal skills, recreation-leisure skills, and relationships with others.

8. Describe the individual's **affective development** such as interest and skills involved with expressing emotions, making judgments, and making independent decisions.

SECTION VI: Medical History and Physical Assessment

1. Does the individual have any medication allergies? ☐ No

If Yes, specify: ______________________________

2. Describe **previous medications** used to treat mental illness symptoms, including current or recent use of medications that could mask or mimic mental illness symptoms. ☐ Unknown

3. Has the client been compliant with medication instructions in the past? Unknown ☐ No ☐ Yes ☐

4. Current Medications. Record current meds, excluding convenience meds or attach current MAR/Physician Orders/POS

☐ Current MAR /Physician Orders/POS attached Date: ______________________

Drug Name	Dosage	Frequency	Start Date

5. Describe individual's response to hypnotics, anti-psychotics, mood stabilizers and anti-depressants, anti-anxiety/sedative agents, and anti-Parkinson agents. ☐ NA

6. Describe the individual's ability to self-administer physician-prescribed medications: ______________________

7. Has the individual had any significant medication changes in the last 30 days? ☐ No If yes, describe:

SECTION VI: Medical History and Physical Assessment (continued)

8. Has the individual received an emergency (STAT) or PRN administration of medications to control behavior in the last 30 days?

☐ No If Yes, describe:

9. List all current and historical medical diagnoses as documented in the individual's record

☐ Current Diagnosis List/History & Physical Attached Date: ____________________

Diagnoses	Status

10. Level of Impact medical/physical health conditions and treatments have on individual's independent functioning

☐ None ☐ Mild ☐ Moderate ☐ Severe

11. Height __________ 12. Weight: __________ 13. Weight trend past six months: ____________________

14. Appetite: ____________________

15. Sleep Pattern **(mark all that apply)**

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep

☐ Receives medication ☐ Severely disturbed pattern ☐ Hypersomnia/daytime sedation

☐ Other: ____________________

16. **Neurological Assessment**. Complete Neurological Assessment or attach current neurological report from medical record.

☐ Completed by PASRR Assessor (Addendum A Attached) **OR** ☐ Neurological functioning addressed in existing medical records

Provider: ____________________ Date: ____________________

17. Summarize Neurological results and describe any abnormal results in motor functioning, sensory functioning, gait, deep tendon reflexes and cranial nerves.

SECTION VI: Medical History and Physical Assessment (continued)

18. **Review of Systems**. Complete Review of Systems or attach current History & Physical with Review of Systems from medical record.

☐ Completed by PASRR Assessor (Addendum B Attached) **OR** ☐ Review of Systems addressed in existing medical records

Provider: ______________________ Date: ______________

19. Summarize Review of Systems/H&P and describe any abnormal results/provide additional comments as necessary:

20. Does the individual currently receive any special **medical treatments**/supports?

☐ No If Yes, please indicate which of the following treatments the individual receives **(mark all that apply)**

☐ Blood transfusions	☐ Foot care	☐ Monitoring of Vital Signs
☐ Bowel and bladder/Incontinence care	☐ Fracture care	☐ Oral suction
☐ Catheterization care	☐ Hemodialysis	☐ Oxygen
☐ Choking/Aspiration precautions	☐ Hospice Services	☐ Prosthesis care
☐ Colostomy/Ileostomy/Ureterostomy	☐ Inhalation therapy/Respiratory care	☐ Seizure precautions
☐ CPAP/BIPAP	☐ Injections	☐ Special skin care/monitoring
☐ Diabetic monitoring	☐ Intake and output	☐ Tracheostomy care
☐ Dietary supplements	☐ IV fluids	☐ Tube feedings/TPN
☐ Decubitus care	☐ IV meds/antibiotics	☐ Weight monitoring
☐ Dialysis	☐ Medication monitoring	☐ Wound/incision care
☐ Fall precautions	☐ Therapeutic diet (specify): ______________	

☐ Ordered labs (specify): ______________________

☐ Other (specify): ______________________

21. Rehabilitation services. Does the individual receive any type of rehabilitative services?

☐ None ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Restorative nursing services

SECTION VII: Mental Status Examination

1. **Cognitive Capacities**. Please write the individual's responses on the lines provided.

☐ Unable or unwilling to participate.

Document current mood/anxiety symptoms/content of thought per record review/staff interview in #6 Observations.

A. What city or town are you in? ______________ ☐ Correct ☐ Incorrect

B. What month is it? ______________ ☐ Correct ☐ Incorrect

C. What season is it? ______________ ☐ Correct ☐ Incorrect

D. What year is it? ______________ ☐ Correct ☐ Incorrect

E. Repeat the following numbers: "8, 7, 2" ______________

F. Beginning with Sunday say the days of the week backwards. ______________

G. Repeat these words after me & remember them, because I'll ask for them later: "hat, car, tree, 26": ____________

H. The opposite of fast is slow. What is the opposite of up? ____________

I. What is the opposite of large? ____________

J. What is the opposite of hard? ____________

K. An orange and banana are both fruits. Red and blue are both? ____________

L. Which is more money -- three dollars or ten quarters? ____________ How much more? ____________

M. What were the words I asked you to remember? ____________

2. **Mood and Content of Thought.** Ask the following questions and **comment on any positive responses in #6 (Observations).**

- ☐ Yes ☐ No A. Do you have episodes of little or no sleep, and still feel energized? ____________
- ☐ Yes ☐ No B. Do you have trouble falling or staying asleep? ____________
- ☐ Yes ☐ No C. Do you feel you sleep too much? ____________
- ☐ Yes ☐ No D. Do you often feel tired or have little energy? ____________
- ☐ Yes ☐ No E. Do you ever feel overly active, restless, fidgety, or have difficulty sitting still? ____________
- ☐ Yes ☐ No F. Are you easily distracted, have trouble concentrating on things, or have racing thoughts? ____________
- ☐ Yes ☐ No G. Do you feel easily annoyed or irritable? ____________
- ☐ Yes ☐ No H. Do you have little interest or pleasure in doing things? ____________
- ☐ Yes ☐ No I. Do you feel down, depressed, or hopeless? ____________
- ☐ Yes ☐ No J. Do you have a poor appetite or feel you eat too much? ____________
- ☐ Yes ☐ No K. Do you feel bad about yourself, like you are a failure and have let your family down? ____________
- ☐ Yes ☐ No L. Do you have thoughts that you would be better off dead or of hurting yourself in some way? ____________
- ☐ Yes ☐ No M. Do you feel nervous, anxious, or on edge? ____________
- ☐ Yes ☐ No N. Do you feel like you worry too much about different things? ____________
- ☐ Yes ☐ No O. Do you feel afraid as if something awful might happen? ____________
- ☐ Yes ☐ No P. Do you have trouble relaxing? ____________
- ☐ Yes ☐ No Q. Have you had any strange or odd experiences lately that you can't explain? ____________
- ☐ Yes ☐ No R. Do you ever hear things that other people can't hear, such as noises or voices of people whispering or talking? ____________
- ☐ Yes ☐ No S. Do you ever have visions or see things that other people can't see? ____________
- ☐ Yes ☐ No T. Do you ever feel that people are bothering you or trying to harm you? ____________
- ☐ Yes ☐ No U. Does it seem like people are talking about you or taking special notice of you? ____________
- ☐ Yes ☐ No V. Do you have thoughts of harming or killing anyone? ____________

3. **Nursing Facility Interest.** What are your thoughts or feelings about going to or remaining in a Nursing Facility? What are your preferences regarding your current and future living situation?

SECTION VII: Mental Status Examination (continued)

4. **Community Interest.** Are you interested in the possibility of returning to live and receiving services in the community instead of a Nursing Facility? ☐ No ☐ Yes

5. **Community Services.** Were you previously receiving any services/supports or participating in any activities in the community that you considered helpful, valuable, or important? If Yes specify: ☐ No

6. **Observations.** Summarize interview and individual's responses to the above Mental Status exam questions, including detail of positive responses. May include personal appearance and dress, attention, motivation, mood attitude, etc. during evaluation process.

NOTE: If the individual was unwilling/unable to participate in the interview document current mood, anxiety symptoms, and content of thought per record review and/or staff interview.

SECTION VIII: Affective Behavioral Observations

1. Orientation ☐ Person ☐ Place ☐ Circumstance ☐ Time ☐ Unable to assess

2. Memory
   - Immediate ____________________
   - Short term ____________________
   - Long term ____________________

3. Affect. **Mark all that apply.**

☐ Appropriate in quality and intensity to stated themes ☐ Angry ☐ Mood congruent
☐ Flat or blunted ☐ Constricted ☐ Mood incongruent
☐ Labile ☐ Other (specify): ____________________

1. Does the individual have a primary diagnosis of Dementia (Major Neurocognitive Disorder), including Alzheimer's disease or a related disorder OR a non-primary diagnosis of Dementia in the absence of a primary diagnosis of a major mental disorder?

☐ Yes ☐ No If Yes, indicate specific symptoms:

- ☐ The individual carries a diagnosis of dementia (major neurocognitive disorder) due to Alzheimer's, Lewy body, vascular dementia, Parkinson's, etc.
- ☐ The individual exhibits memory impairment
- ☐ The individual exhibits at least one of the following:
  - ☐ Aphasia ☐ Apraxia ☐ Agnosia ☐ Disturbance in Executive Functioning

Do cognitive impairments interfere with the individual's ability to participate in, and benefit from, traditional mental health services? ☐ Yes ☐ No

Are Dementia related symptoms the primary focus of concern and/or are more prominent than symptoms of a major mental disorder? ☐ Yes ☐ No Describe:

If you answered "YES" to ALL of the above questions the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.

2. Does the individual have a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders including schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability?

☐ No (check all that apply)

- ☐ Individual's current condition is such that assessment results may not be reflective of their typical behavior (due to acute medical illness, delirium, etc). SMI determination cannot be made at this time. Recommend re-evaluation at a later time.

  Describe: ____________________
- ☐ Individual has a major mental disorder diagnosis, but unable to verify with available information. Further evaluation needed.

  Describe: ____________________

☐ Yes (check all that apply)

☐ Anorexia Nervosa or other eating disorder	☐ Bi-polar Disorder	☐ Major Depressive Disorder
☐ Somatic Symptom Disorder/Conversion Disorder	☐ Delusional Disorder	☐ Schizophrenia
☐ Obsessive-Compulsive Disorder	☐ Panic Disorder	☐ Schizoaffective Disorder
☐ Dissociative identity Disorder	☐ Stressor-Related Disorder (PTSD)	☐ Mood Disorder
☐ Psychotic Disorder	☐ Dysthymic Disorder	

- ☐ Personality Disorder (paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, etc)

  Specify: ____________________
- ☐ Severe Anxiety Disorder (panic disorder, agoraphobia, generalized anxiety disorder, etc)

  Specify: ____________________
- ☐ Other mental disorder in the DSM (specify): ____________________

If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.

3. Indicate specific symptoms to support the DSM-V criteria for the disorder indicated above. Summarize symptoms, precipitating factors, onset, duration and intensity that support the diagnosis.

4. **As a result of the previously indicated major mental disorder,** has the individual experienced functional impairment which has substantially affected one or more major life activities (including ADLs; instrumental ADLs; or functioning in social, family, and academic or vocational contexts), or would have caused functional impairment without the benefit of treatment or other support services?

☐ No ☐ Yes (check all that apply)

☐ **Interpersonal Functioning:** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships, impairment of social/family relationships, or social isolation

☐ **Adaptation to Change:** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interactions; agitation; exacerbated signs and symptoms associated with the illness or withdrawal from situations; self-injurious, self mutilation, suicidal (ideation, gestures, threats or attempts); physical violence or threats; appetite disturbance; delusions; hallucinations; serious loss of interest; tearfulness; irritability; or requires intervention by mental health or judicial system.

☐ **Concentration, Persistence and Pace:** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings; difficulties in concentration; inability to complete simple tasks within an established time period; makes frequent errors or requires assistance in the completion of these tasks, or has impairment of ADLs/IADLs.

If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.

5. As a result of the previously indicated major mental disorder, has the individual required intensive mental health services (more intensive than routine follow up care) provided by mental health professionals to stabilize or maintain a person experiencing a significant disruption of their major mental disorder in the last 2 years.

☐ Yes ☐ No If Yes, specify the type of services (check all that apply):

☐ Inpatient psychiatric hospitalization, partial hospitalization program, psychiatric residential treatment center

(Specify date/provider): ____________________

☐ Referral to mental health crisis/screening center or program, or hospital emergency department

(Specify date/provider): ____________________

☐ Intervention by housing or law enforcement officials (Specify): ____________________

☐ Psychiatric consultation or other services by MH professionals, DMH/CPS community mental health services, or MH primary reason for NF/RCF/ALF admission or continued stay

(Specify date/provider): ____________________

☐ Treatment history for the past two years is unknown or treatment was unavailable but otherwise appropriate to consider the person positive for serious mental illness

If you answered "NO", the individual DOES NOT meet criteria for a PASRR related mental health disability. Go to Question #6.

6. Has the individual been diagnosed with Intellectual Disability (ID) that results in significantly sub-average general intellectual functioning, **originating before age eighteen (18)**, that is associated with significant impairment in adaptive behavior (Note: Do not include Borderline Intellectual Functioning)? ☐ Yes ☐ No

   If Yes indicated level of impairment: ____________________

7. Does the individual have a related condition other than mental illness resulting in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons? ☐ Yes ☐ No If Yes, **mark all that apply:**

   - ☐ Cerebral Palsy
   - ☐ Down's Syndrome
   - ☐ Epilepsy/Seizure Disorder
   - ☐ Traumatic Brain Injury
   - ☐ Spinal Cord Injury
   - ☐ Multiple Sclerosis
   - ☐ Muscular Dystrophy
   - ☐ Autism Spectrum Disorder (Asperger's Syndrome, Pervasive Developmental Disorder)
   - ☐ Severe Hearing and Visual Impairment
   - ☐ Spina Bifida or other neural tube defect
   - ☐ Fetal Alcohol Syndrome
   - ☐ Fragile X Syndrome or other genetic disorder
   - ☐ Prader-Willi Syndrome
   - ☐ Para/Quadraplegia or other orthopedic impairment
   - ☐ Other (specify): ____________________

   Was the impairment **manifested before the person reached the age of 22**? ☐ No ☐ Yes

   Is the impairment likely to continue indefinitely? ☐ No ☐ Yes

   As a result of the above diagnosis, the individual has substantial functional limitations in the following areas of major life activity prior to age 22. **Mark all that apply.**

   - ☐ Self Care
   - ☐ Mobility
   - ☐ Understand and use of language
   - ☐ Learning
   - ☐ Self Direction
   - ☐ Capacity for independent living
   - ☐ No functional limitations

8. Indicate specific results of intellectual functioning measurements, or other methodology used to make determination of intellectual disability. If formal testing results are unavailable, clearly document collateral information that supports the determination of intellectual/developmental disability or related condition.

9. Based on the previous questions, the individual: **Select One.**

   - ☐ Has IDD OR has related condition other than mental illness as defined by PASRR.
   - ☐ Does not have, or absence of clear evidence to substantiate/validate, IDD or related condition as defined by PASRR.

If unable to confirm ID/DD/RC diagnosis, the individual DOES NOT meet criteria for a PASRR related ID disability.

If the individual DOES NOT meet criteria for a PASRR related mental health disability and DOES NOT meet criteria for a PASRR related ID disability proceed to Section: Conclusions.

SECTION IX: PASRR Level II Evaluation Report (continued)

10. Provide a **summary** of the client's medical and social history

11. Individual's **limitations** (developmental needs, physical, communication, memory, needs, etc.)

12. Individual's **strengths** (positive traits and developmental strengths, abilities, accomplishments, personal traits, etc.)

13. Has a prospective Nursing Facility been identified? No ☐ N/A (Currently in NF) ☐

If Yes, please indicate facility name: ____________________

14. Is the level of support for ADLs and other identified needs such that the individual's total care needs could be met in a nursing facility?

☐ Yes, the individual's needs could be met in a nursing facility at this time.

☐ No, the individual's needs cannot be met in a nursing facility at this time (**check all that apply**):

- ☐ Requires 1:1 supervision to maintain safety due to behavioral/mental health symptms
- ☐ Recent/current aggressive/violent behavior requiring seclusion, restraints, PRN medications etc.
- ☐ Current/active homicidal ideation
- ☐ Current/active suicidal ideation/self harm
- ☐ Medication refusal leading to acute exacerbation/continuation/instability of psychiatric symptoms
- ☐ Other (specify): ____________________

If the individual requires services beyond the capabilities of a nursing facility contact Bock before proceeding and skip to Section: Conclusions.

15. Could alternatives to NF services be considered at this time? ☐ Yes ☐ No

SECTION IX: PASRR Level II Evaluation Report (continued)

16. Provide discussion/supporting documentation for Nursing Facility recommendation including community alternatives to NF and services and supports provided to the individual prior to considering NF placement.

17. The individual needs or continues to need the following supports and services.

- ☐ A. Provision of specific services to address the individual's **mental health and behavioral needs**.
  - ☐ Obtain Individual Support Plan (ISP), Individualized Treatment Plan (ITP), Behavioral Support Plan (BSP) from DMH Community Mental Health Center and/or Developmental Disability Regional Office.
  - ☐ Monitoring of behavioral symptoms
  - ☐ Trauma informed services
  - ☐ Tools of choice or other Positive Behavioral Support services

  Identify and describe behaviors to be addressed in the NF plan of care:

- ☐ B. **Medication** therapy and monitoring services
  - ☐ Psychiatric follow up to prescribe and manage medications
  - ☐ Medication set up/administration by staff and monitoring for compliance with prescribed medication
  - ☐ Monitoring of interaction or adverse effects (AIMS, etc)
  - ☐ Monitoring of therapeutic effect in managing mental health symptoms including labs as indicated
  - ☐ Address, report, and implement plan to manage patient refusals/noncompliance (including cheeking, hoarding, etc.)
  - ☐ Provide education/training in drug therapy management
  - ☐ Pharmaceutical services/medication review
  - ☐ Other: ______________________

☐ C. Provision of a **structured environment**.

☐ Maintain environment with low stimulation
☐ Provide for individual personal space
☐ Maintain environment with a minimum of visual/auditory distractions
☐ Provide for sensory supports
☐ Provide instructions at the individual's level of understanding
☐ Establish consistent routines
☐ Environmental supports to prevent elopement
☐ Provide schedule of daily tasks/activities
☐ Assess and plan for the level of supervision required to prevent harm to self or others

List needs and rationale as well as level of supervision needed:

☐ D. Implementation of **ADL program** to increase independence and self determination.

Assess and plan a program for the development and maintenance of necessary living skills including **(mark all that apply)**:

☐ Grooming/dressing
☐ Nutrition needs
☐ Bathing
☐ Personal Hygiene
☐ Money Management
☐ Maintenance of own living environment
☐ Toileting/bowel/bladder
☐ Other: ________________

By providing the following services **(mark all that apply)**

☐ Physical therapy evaluation and/or treatment
☐ Occupational therapy evaluation and/or treatment
☐ Speech-language pathology evaluation and/or treatment
☐ Restorative services (for turning/positioning, transferring, ambulation, ADLs, range of motion, bowel/bladder program
☐ Provision of, training or assistance in use of adaptive equipment or assistive devices
☐ Dietary or nutritional services
☐ Provide cueing, reminders, education and/or modeling of daily living skills

☐ E. **Crisis Intervention** Services. Assess and plan for Crisis Intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis. A crisis plan should developed to create clear steps that are to be taken to support client during a behavioral health crisis including who to contact for assistance, how to work together with client during the crisis, and how to determine when the crisis is over. The plan should also identify a physician and emergency medical services that should be contacted. Facility may also wish to utilize DMH Behavioral Health Crisis Hotline: https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/behavioral-health-crisis-hotline

☐ Suicidal precautions
☐ Assault precautions
☐ Elopement precautions

☐ F. Development of **Personal Supports**

- ☐ Assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc.
- ☐ Assess, plan, and develop appropriate personal support network through community and social connections.

☐ G. Assess and plan for **discharge**, transition to less restrictive environment by application/referral to appropriate community resources. Facility/staff to make referral and assist with application for resources and/or services. Describe and specify:

Identify what supports/services may be needed for the individual to live successfully in a **less restrictive/community setting**.

- ☐ Community based substance abuse treatment
- ☐ Community based psychiatric treatment and supports
- ☐ 12 step/substance abuse program
- ☐ Behavioral supports/supervision
- ☐ Day programming/Adult day care
- ☐ Family support/education
- ☐ Financial assistance/eligibility evaluation
- ☐ Group counseling/psychotherapy/support group
- ☐ Hospice services
- ☐ Housekeeping/homemaker services
- ☐ Individual counseling/psychotherapy
- ☐ Medication education/counseling/set-up/admin
- ☐ Occupational therapy evaluation
- ☐ Physical therapy evaluation
- ☐ Referral to DMH/DD Regional Office for intake/eligibility evaluation, community services
- ☐ Residential services/supported housing
- ☐ Skills training/vocation rehabilitation/supported employment
- ☐ Social Work services/Case management
- ☐ Speech/language therapy evaluation
- ☐ Adaptive equipment evaluation (specify): ____________________
- ☐ Home health nursing services (specify): ____________________
- ☐ Medical follow up/Physician services (specify): ____________________
- ☐ Nutritional/dietary evaluation/meal or shopping assistance (describe needs): ____________________
- ☐ Personal care/ADL assistance (specify): ____________________
- ☐ Other (describe): ____________________

SECTION IX: PASRR Level II Evaluation Report (continued)

18. Describe any additional information to be utilized by the nursing facility for care planning purposes.

SECTION: Conclusions

Source of information used in completing evaluation:

- ☐ Client interview
- ☐ Record review - current facility
- ☐ Previous PASRR (date): ____________________
- ☐ CIMOR
- ☐ Record review - previous facility (specify): ____________________
- ☐ Record review - Regional Office (specify): ____________________
- ☐ Staff interview (specify): ____________________
- ☐ Family/guardian (specify): ____________________
- ☐ Case Manager (specify): ____________________
- ☐ Other (specify): ____________________

Assessor Name: ____________________ Date: ____________________

Signature: *** Signature on File *** Title

For BOCK USE ONLY:

Reviewed/Edited by: ____________________ Date: ____________________